AMHS - NON-WORK RELATED
EMPLOYEE'S REPORT OF MARITIME INJURY OR ILLNESS

(see reverse side for guidance)

Distribution:
Copy to Vessel
Copy to Master (Weekly Report)
Copy to ADOT Personnel/Payroll -- (as needed)
Copy to Safety Officer

(Examples of **Non-Work Related** – **Injury**: on board as a passenger; **Illness**: tooth ache, flu, family emergency, in grown toenail, etc.)

1. EMPLOYEE DATA: Union: _____ [ ] MM&P [ ] IBU [ ] MEBA

Name: _____ Social Security No: **(last four digits only)** _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

(Home)
Telephone No. (_____) _____ - _____ Date of Birth: ____/____/____ [ ] Male [ ] Female

Occupation: _____ Department: [ ] Purser [ ] Steward [ ] Deck [ ] Engineering

Supervisor: _____ Wages: $_____ *Per - [ ] Hour [ ] Month*

Work Week Began: _____/_____/_____ End: _____/_____/_____ Shift Began: _____ AM / PM

[ ] Employee an assigned crew member [ ] Employee an assigned Relief [ ] Employee onboard as a passenger

2. EMPLOYEE'S DESCRIPTION OF [ ] INJURY or [ ] ILLNESS ⇦ (check one)

Location: [ ] **Vessel Name:** _____ [ ] Other Location: _____

Date & Time Injury / Illness Occurred: Date: ____/____/____ Time: _____AM / PM

Date & Time Left Work: Date: ____/____/____ Time: _____AM / PM [ ] Did Not Leave Work

Date & Time Returned to Work: Date: ____/____/____ Time: _____AM / PM

Describe the nature of Injury / Illness: _____
_____
_____

Did you seek or receive medical treatment onboard the vessel? [ ] YES [ ] NO
Are you planning to, or did you, seek medical care off the vessel? [ ] YES [ ] NO

3. WITNESS(es): *(NOTE: If more space needed, attach separate sheet)* **[ ] No Witness**

Name: _____ Address: _____ [ ] Crew Member [ ] Passenger

4. SIGNATURES:

Employee's Signature: _____ Date: _____/_____/_____ Time: _____ AM / PM

Reported To: _____ Date: _____/_____/_____ Time: _____ AM / PM

Vessel Master: _____ Date: _____/_____/_____

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The following instructions are guidelines for completing this report (AMHS 05/05). **You must ensure all pertinent data/information blocks are completed with as much detail as possible**. The majority of the form is self explanatory - however, the following is guidance for certain blocks (data-fields): If more space is needed, attach additional paper and ensure it (1) references this particular injury/illness; and (2) is signed and dated.

1. EMPLOYEE DATA BOX: ✍

Union ---------- Check the appropriate one or write the commonly used acronym for the employee's union, or spell it out.
Name ---------- Vessel employee's first, middle initial, and last name(s).
SSN ---------- Give employee's Social Security Number. **(last four digits only)**
Physical Address ------- Give full address. *Cannot be a P.O. Box, must be a physical (e.g. Street) address.*
Mailing Address -------- If it is the same as Physical Address just write the word "SAME".
Telephone No.---------- Give the individual's home number, not their work number.
DOB ---------- Give employee's Date of Birth.
M or F ---------- Check whether employee is Male or Female.
Occupation ---------- Write the position/title of the employee (e.g. Steward, A/B, Jr. Engineer, etc).
Department ---------- Write name of the Department the employee is with (e.g. Deck, Steward, Engineering, etc.)
Supervisor ---------- Give the name and title of the employee's Supervisor.
Wages ---------- Self explanatory. Check if per HOUR or per MONTH.
Workweek Began/End - Give the date: the employee's work week **began**, and was scheduled to **end.**
Shift began ---------- Employee's watch, e.g. 0600-1200 (use 24 hour clock times).
Employee onboard ----- Check the one that accurately describes why the employee was onboard.

2. EMPLOYEE'S DESCRIPTION OF INJURY OR ILLNESS BOX: ✍

NOTES: (1) **This section must be in the Employee's own words & handwriting**. If not, the reason it isn't must be stated and the name of the individual filling it out must be indicated on this form or an attached sheet.
(2) If more space is needed, for any portion, attach an additional sheet that is signed and dated by the employee.
(3) Check either the INJURY box or the ILLNESS box.

Location ---------- (*) If Vessel - check box and write the name of vessel. (*) If Other - write the exact location of the injury/illness. (*) Attach diagrams and/or photographs - as appropriate.
Dates ---------- Self explanatory. **All dates are to be mm/dd/yy, (e.g. 07/15/98 = July 15, 1998).**
Nature---------- Fully describe exact nature of the injury or illness. Medical terminology is not mandatory. Also, briefly-but fully-describe part of the body that was injured or affected by the injury/illness, including which side (e.g. left arm, right leg, and so forth).
Medical Treatments: - ONBOARD: If the employee sought or received medical treatment for their injury or illness onboard, check the appropriate box.
ESLEWHERE: If the employee did or is planning to seek medical treatment off the vessel, check the appropriate box.

3. WITNESS: Give full name and address of witnesses, and check whether they're a crew member or passenger.

4. SIGNATURE BOXES:

(a) Employee just signs in their space. **Signatures are required for each individual listed!**
(b) The "Reported To" individual - - is the first crew member (normally the employee's supervisor) the employee reported the injury/illness to.
(c) For the "Reported to" and "Vessel Master", please print or type the individuals name, include title/position, then have them sign above it - prior to submittal.
(d) The Employee & Reported To individual must include the time (use 24 hour clock times) of their signature.

IMPORTANT NOTE: If any of the signers has additional information to add or disagrees with what the employee states, attach a signed and dated statement from/for each signer.

DISTRIBUTION OF COPIES: Self explanatory (see distribution box – upper right-hand corner).

☞ ***AS REQUIRED, SUBMIT A "FIT / UNFIT FOR DUTY" FORM PROMPTLY!***